



**STATE OF TENNESSEE  
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES  
OFFICE OF CONSUMER AFFAIRS  
CORDELL HULL BUILDING, THIRD FLOOR  
425 5<sup>TH</sup> AVENUE NORTH  
NASHVILLE, TENNESSEE 37243**

**CERTIFIED PEER SUPPORT SPECIALIST  
ON-GOING EDUCATION VERIFICATION**

An individual, who is certified as a Peer Support Specialist, shall satisfactorily complete a minimum of twenty (20) hours of continuing education trainings, including Ethics, Title 33, Cultural Competency, Co-Occurring Disorders and HIPPA in conjunction with the certification renewal process. Only continuing education trainings recognized by the TDMHDD Office of Consumer Affairs shall be used to satisfy the continuing education requirement.

- Do not alter the form from its original format.
- Write legibly in only black or blue ink.
- Do not use nicknames or abbreviated forms of your legal name.

Name (*please print*): \_\_\_\_\_

Certification Number: \_\_\_\_\_ Certification Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

List the name, date, sponsoring organization / association / agency and the number of hours for each on-going training attended.

1) _____	_____
Name of On-Going Education	Sponsor
_____	_____
Number of Training Hours	Date

2) \_\_\_\_\_  
Name of On-Going Education Sponsor

\_\_\_\_\_  
Number of Training Hours Date

3) \_\_\_\_\_  
Name of On-Going Education Sponsor

\_\_\_\_\_  
Number of Training Hours Date

4) \_\_\_\_\_  
Name of On-Going Education Sponsor

\_\_\_\_\_  
Number of Training Hours Date

**My signature below affirms that all of the information attached to and contained in this verification form is true and correct to the best of my knowledge. I understand that knowingly providing false information shall be grounds to terminate my certification.**

\_\_\_\_\_  
Signature of Applicant Date

**Do Not Write Below This Line**

\_\_\_\_\_  
**Internal TDMHDD – OCA Use Only**

Date received: \_\_\_\_\_

Date reviewed: \_\_\_\_\_ Approved \_\_\_\_\_ Not-approved \_\_\_\_\_

Date letter of findings mailed to applicant: \_\_\_\_\_

Date information recorded in data-base: \_\_\_\_\_

Notes:

Processed by: \_\_\_\_\_